Adult Care Home Providers' Instructions for Preparing the UB-92 Claim

Form Locator/Description	Requirements	Remarks
1. Provider Name/Address	Required	Enter name of the facility and 1-3 lines of address. Please use the same name and mailing address you entered on your Medicaid Provider Agreement or the name/address shown on your Remittance Advice (RA) report. Do not abbreviate.
2. Patient Control Number	Optional	You may enter your facility's medical record number or other control number for identifying the resident if you want it to appear in the Medical Record field of the RA. You may enter up to 20 digits, letters or numbers, but only the first nine digits will appear on the RA.
4. Type of Bill	Required	Enter 893
6. Statement Covers	Required	Enter the beginning and ending dates of the time period covered by this bill using **eight** digits for the day, month and year (MMDDYYYY). For example, January 15, 2000 is 01152000. Dates entered here may not be earlier than the Admission Date entered in Form Locator 17. • The FROM date is the earliest date of service on this bill. • The THROUGH date is the last date of service on this bill. If the resident died or was discharged during the time period covered by this bill, the date of death or discharge is the THROUGH date. Bill only for dates that the resident is eligible for Medicaid and only for dates in one calendar month.

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12. Patient Name	Required	Enter resident's name exactly as it appears on the Medicaid ID card: last name, first name, and middle initial. Please do not use nicknames or abbreviations.
14. Patient Birthdate	Required	Enter the resident's date of birth using **eight** digits for the day, month, and year (MMDDYYYY). • For example, October 24, 1898 is 10241898
17. Admission Date	Required	Enter the date the resident was admitted to the facility using **eight** digits for the day, month, and year (MMDDYYYY). • For example, December 15, 2000 is 12152000. The admission date entered here may be the same date as, but no later than, the FROM date in Form Locator 6.
22. Patient Status	Required	Enter one of the two digit codes below to show the status of the resident at the time of the last date of service on this bill (the THROUGH date entered in Form locator 6). **01** Resident was discharged to home or self-care (routine discharge) on the THROUGH date entered in Form Locator 6. **02** Resident was discharged or transferred to a hospital, nursing facility, or other facility on the THROUGH date entered in Form Locator 6. **20** Resident died while in this facility on the THROUGH date entered in Form Locator 6. **30** Resident was still residing in this facility on the THROUGH date entered in Form Locator 6.

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Appendix K. Revenue Code	Required	From the revenue codes listed below, enter the three digit code of the service(s) you are billing on this claim form: 599 ACH/PC (Basic or Enhanced) 183 Therapeutic Leave 229 Transportation You may bill all of these services on the same claim form.
Appendix K. HCPCS Code **When you submit your claim for an enhanced care rate, you must also submit a separate detail line for Basic ACH/PC.** **Refer to UB-92 claim examples #1 thru #9 in Appendix K.**	Required	**Effective 1/1/2000** To file a claim for providing Therapeutic Leave, enter W8251 (Licensed Beds 1-30) or W8258 (Licensed Beds 31 & above) on the same detail line(s) as Revenue Code 183. To file a claim for providing Transportation, leave this item blank on the same detail line as Revenue Code 229. To file a claim for providing Basic ACH/PC, enter W8251 (Licensed Beds 1-30) or W8258 (Licensed Beds 31 & above) on the same detail line(s) as Revenue Code 599. To file a claim for providing Enhanced ACH/PC for a resident who needs extensive/total assistance with Eating, enter W8256 on the same detail line(s) as Revenue Code 599. To file a claim for providing Enhanced ACH/PC for a resident who needs extensive/total assistance with Toileting, enter W8257 on the same detail line(s) as Revenue Code 599. To file a claim for providing Enhanced ACH/PC for a resident who needs extensive/total assistance with both Eating and Toileting, enter W8259 on the same detail line(s) as Revenue Code 599. To file a claim for providing Enhanced ACH/PC for a resident who needs extensive/total assistance for Ambulation/Locomotion enter W8255 on the same detail line(s) as Revenue Code 599.

Form Locator/Description	Requirements	Remarks
45. Service Date	Required	For each claim for Basic ACH/PC, Enhanced ACH/PC, Therapeutic Leave, or Transportation on this bill, enter the first date of service being billed on the corresponding detail line. Use **eight** digits to show the day, month, and year (DDMMYYYY).
46. Service Units	Required	For each claim for Basic ACH/PC, Enhanced ACH/PC, Therapeutic Leave, or Transportation on this bill, enter the total number of dates of service being billed on the corresponding detail line. Be sure that the dates of service (DOS) billed for Therapeutic Leave do not overlap DOS billed for Basic ACH/PC and/or Enhanced ACH/PC. Transportation dates of service may overlap Basic ACH/PC, Enhanced ACH/PC, or Therapeutic Leave dates of service. If the resident was admitted to the facility during the time period covered by a detail line, you may count the date of admission to the facility as a date of service. In this situation the admission date in Form Locator 17 is the same as the FROM date in Form Locator 6. If the resident died at the facility during the time period covered by a detail line, you may count the date of death as a date of service. If the resident was discharged to home, a hospital, nursing facility or other facility during the time period covered by a detail line, do not count the discharge date as a date of service.
51. Provider Number	Required	Enter the unique 7 – digit provider number assigned to your facility by Medicaid. Your provider number appears on the letter returned to you with the signed Provider Agreement. Do not add extra zeros or dashes. The provider number on the claim must be the provider number of the adult care home where the resident resided on the dates of service billed.
60. MID Number	Required	Enter the resident's ten digit Medicaid ID number as it appears on the Medicaid ID Card. There are nine numbers followed by one letter in a Medicaid ID number.

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85. Provider Representative Signature	Required	The person authorized to file the claim for the facility signs the form here. A written signature is desired however, a signature stamp is acceptable.
86. Date Bill Submitted	Required	Enter date the claim is being submitted.

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